# TELEMEDICINE AND COVID-19 FAQ

AMERICAN ACADEMY OF NEUROLOGY®

*The AAN developed this guidance as a companion to the Telemedicine and COVID-19 Webinar for clinicians and practices looking to implement telemedicine services amid the COVID-19 crisis. Regulations discussed below have effective dates of March 6, 2020[1], for the duration of the Public Health Emergency as determined by the Department of Health and Human Services. Because of the unique nature of a Public Health Emergency, some guidance may not align with the AAN's overall Telemedicine Position, which was created in and intended for non-emergency periods.*

*Additionally, state and local regulations may supersede the federal regulations outlined in this document. If your institution or practice has existing telemedicine programs, we encourage you to communicate with your compliance, coding, and IS teams to understand internal telemedicine policies and procedures.*

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[1] As determined by CMS. Other payers and states may have a different starting date.

# IMPLEMENTATION / SET UP QUESTIONS

## Vendor

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| Are Zoom, Doxy.me, and Vidyo HIPAA compliant? | Yes, they all have HIPAA compliant options. You will need to execute a BAA and retain for your records. |
| Can we use the Healow system, Google Duo, or Jitsi platform for telemedicine encounters? | You can use any video platform. HHS is not enforcing penalties for non-HIPAA compliant telemedicine visits during the COVID-19 Public Health Emergency. We recommend ensuring HIPAA compliance to avoid penalties after the Public Health Emergency has ended. |
| Is the Vidyo system able to connect to other EHR systems, or just EPIC? | We recommend contacting your EHR vendor to discuss video integration capabilities. |

## Connecting with Patients

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| If we try telemedicine with individuals located in their home or group home/ care facility, what capabilities does the patient need? If we use Zoom or Doxy. me, do they have to have an equivalent (paid for) app? | They need to be able to establish a real-time bidirectional audio and video connection with the provider. For Zoom, the app is free. You can send the patient the link and meeting ID. For Doxy.me, there are no downloads or account set up, the patient needs to search for their doctor's room which you can share with them in advance. |
| Are Zoom, Vidyo, and Doxy.me easy for patients that are not as tech savvy? I have never used these applications and as a solo practitioner don't have a lot of time to provide technical support to patients. | Yes, they are all intuitive to use. If you have support staff, we recommend they call the patient to test and troubleshoot patient needs prior to the appointment. |
| How do you leverage interpreters into telehealth? | Policies vary by institution. One method includes connecting with an interpreter via a separate phone line. |
| Can I (as the physician) perform telemedicine from home and still bill for the service, or do I need to be at the practice site? | Yes, you can be at home. We recommend being mindful of HIPAA protections when in the home environment including family members should not be able to hear or see patient interactions, nor have access to clinic information via a work computer. |
| How do you recommend handling telemedicine visits for patients with a vision or hearing impairment? | We recommend using the assistance of a family member or caregiver that is with the patient. When scheduling the appointment, ensure a caregiver will be present. |
| How do we recommend managing equipment/physical setting limitations on the patient end such as internet speed, lighting, etc.? | We recommend using your office support staff to call the patient to test and troubleshoot patient needs prior to the appointment. |
| For a telephone visit or virtual check in, can the interview be completed with caregiver if the patient has dementia? Can a caregiver provide consent? | Yes. Document that the patient is unable to consent due to dementia, who the interview is being conducted with, and the caregiver's role in the patient's care. |

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| I understand the patient must initiate the phone call to report a telephone consult service. If the provider is at his/her home how can the phone call be generated by the patient? | It is the responsibility of the provider to roll over or transfer calls received at the clinic to the physician in their remote setting. |
| If I give my patient the option of doing a phone visit instead of an in-person visit, does that count as patient "initiated?" | Yes. |

# REGULATIONS / WAIVER QUESTIONS

## State Level

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| Regarding state licensure and crossing state lines, does that include an established patient who is currently "vacationing" in another state and telehealth visit was conducted during the vacation? | You need to confirm with the state in which you are licensed and your malpractice carrier. Larger institutions may have additional policies. |
| Can we perform telemedicine across state lines? | At the federal level, having a license in any state allows you to treat a patient in any state. However, states also need to agree to this; we recommend checking with your state to ensure compliance. Visit this website for additional information. |
| In my state, for most telemedicine visits, there was a stipulation that patients had to be offered an in-person visit but selected to be seen via telemedicine. Do you know if this stipulation has been waived due to the COVID crisis, or do patients still have to have the option to be seen in person? | We recommend you check with your state regarding their current regulations. We've found state medical boards and governor websites to be helpful when finding current information. |
| If I understood clearly, the governor of any state can require equal pay for audio-only visits even if CMS requires video? Is this correct? | We recommend you check with your state regarding their current regulations. We've found state medical boards and governor websites to be helpful when finding current information. |

## Location

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| Do I (as the provider) need to physically be in United States to perform telemedicine? | Not that we are aware of, but it is best practice to check with your institution, the state in which you are licensed, and your malpractice carrier. |

### New vs. Established

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| Are there legal waivers for treating a new patient you have never seen in person? | None that we are aware of. Institutions may have varying policies regarding seeing and evaluating new patients remotely. |
| I understand CMS will not be conducting audits to validate established patient performed via telemedicine, but 99201–99205 are approved for telehealth? Is this correct? | That is correct. They have not waived the requirement of having an established relationship, however during this time, they will not be auditing. |
| Are the new vs. established patient rules the same for telemedicine? Does established specifically mean known/seen by a provider in the past or does the patient who has been established in the practice suffice? | The same rules for new vs. established patients that exist for outpatient E/M services applies for telemedicine services. "Has the patient received any professional services from the physician/qualified health care professional or another physician/qualified health care professional in the same group of same specialty within the past three years?" |
| Do you recommend doing new consults virtually without performing an exam? | You cannot bill a new consult visit without an exam. You do need the exam, otherwise you could bill the encounter as a phone visit. |

### Medications

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| Is the waiver on controlled substances a temporary one, or is it permanent? Can you briefly summarize the rules for Controlled Substances/DEA? | It is temporary, effective for the duration of the Public Health Emergency. You can prescribe controlled substances using any method currently available, including electronically. Prescriptions for schedule 2 drugs are allowed for up to 90 days (multiple scripts) and early refills are allowed for schedule three to five drugs. Prescriptions across state lines are also permitted. Please visit this site for more information.<br><br>Additionally, we recommend checking your state to ensure compliance with state regulations, e.g., checking PMP. |

## EXAM / CLINICAL QUESTIONS

### Documentation

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| Has Medicare waived any of their documentation requirements? | No; documentation requirements remain the same. |
| Do we need to have a proof that the patient was seen through telemedicine? Any screen shots or patient pictures required. Do we have to document timing and duration of the visit? | You do not need video or picture recordings stored in the patient's chart or encounter. You do need to document that the visit was conducted via video visit and that you have the patient's consent to conduct the visit in this manner. You do not need to specify start and stop times of the visit, but if you determine the level of service by time, then you need to document the time of the encounter. |

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| Regarding the malpractice issue of telemedicine, the examination is limited under telemedicine and important signs may be missed with potential effect on outcomes. If so, what exactly can we comfortably do on telemedicine? | Generally, if you are unable to perform an exam with 100-percent certainty, then you should recognize this as a limitation of telemedicine practice and document as such. Best practices include avoiding "guessing" over telemedicine. You can document that, based on your exam, the patient appears to have [XYZ] findings but this is a limited evaluation by telemedicine evaluation. A telemedicine exam is primarily focused on the history and what you can observe. You may recommend an in-person evaluation if the patient needs it to establish the diagnosis or treatment plan with greater certainty. |
| Does patient consent need to be written, too, or is verbal enough? Also, if a patient is scheduled specifically as a telemedicine visit, does that imply verbal consent? | No, during the Public Health Emergency, patient consent does not need to be written. Consent needs to be documented in the note of each visit; scheduling the appointment as a telemedicine visit does not imply consent. |
| If I am performing inpatient telemedicine consults, how do I obtain consent on an intubated or sedated patient. Our hospital is on lock down so no visitors allowed, therefore no surrogate member to give consent. | Inpatient visit consents are covered under the hospital overall consent for care. Double check with your institution and work with your institution to add telehealth language in the admission consent form. |
| Are we required to document the originating site during the COVID-19 crisis? | We recommend documenting the originating site and that the visit took place during the COVID-19 Public Health Emergency. |
| What exam elements are absolutely required with telehealth visits in order to bill for standard E/M codes? | The same elements that are required for in office visits are required for telemedicine visits. |
| Does a telehealth visit need to have the full ROS like our typical clinic notes to be a covered service? Also, do we need to have all other sections (family history, social history, etc.)? | The requirements are the same as those for in-person encounters: If you determine the level by elements of history, exam, MDM, yes. If you determine the level by time, no. |

## Examining the Patient

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| All the exam components suggest a stationary camera. How do we perform a neuro exam for a patient who lives alone connecting on their cell phone? | We suggest the patient uses a stand or find a way to prop their phone so they can be hands free. |
| How do we handle the fact that vitals are unable to be obtained? | If the patient has a scale and/or blood pressure cuff, you can document the readings and that it was on patient-owned equipment. |
| If the patient has a neurologic disorder that limits their ability to respond to our commands, how can we perform the clinical exam via telemedicine in this situation? | We recommend using the assistance of a family member or caregiver who is with the patient. When scheduling the appointment, ensure a caregiver will be present. |

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| Can you clarify how to perform fundoscopic exam? Would the patient need a special lens on their phone? | This is more suitable for telemedicine exams which are not performed in the patient home. There are tele-ophthalmoscopes that can be used with a dedicated telemedicine cart and telepresenter. Here are some tips from the American Academy of Ophthalmology. |
| Is the MoCA blind licensed? How practical is performing the tapping portion of the MoCA given the time delay of audio/video? | Please see this Remote MoCA Testing reference. |

# CODING / BILLING QUESTIONS

## Who Can Bill

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| Are non-physician health care providers authorized to participate in telemedicine? | Yes, telemedicine visits can be performed by MD, DO, and APPs. Residents and fellows are also allowed to participate in telemedicine when direct supervision is maintained according to ACGME's definitions. See CMS language on supervision below. |
| Regarding incident-to billing, if we (physician and other clinical staff) are connected electronically but not in the same room is this considered offsite? If the physician can see the screen, is this the same as being in the same room? | If the APP is providing a telemedicine visit and the supervising MD is readily available during the visit to assist, you can meet the incident-to guidelines. If the APP is performing a telemedicine visit from their residence and the supervising MD is not available synchronously, this would not and would need to be billed under the APP's NPI. |
| Have we heard any updates from CMS on how to bill and include residents for teaching physicians? Our understanding is that in order to bill for total time, we will need to teleconference with the resident and the patient at the same time. Is this accurate? | Under current rules, Medicare payment is made for services by a teaching physician involving residents only if the physician is physically present for the service or procedure. Teaching physicians can provide services with medical residents virtually through audio/video real-time communications technology. This does not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services. This allows teaching hospitals to maximize their workforce to safely take care of patients.<br><br>Institutions are turning to the ACGME for guidance. Effective immediately, the ACGME will permit residents/fellows to participate in the use of telemedicine to care for patients affected by the pandemic, and defines Direct Supervision as: "the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology." Ultimately, each specialty Review Committee will choose whether to continue to allow for this type of direct supervision with telemedicine in other situations. In no situation will a program be penalized retroactively for appropriate engagement of residents and fellows with appropriate supervision in the use of telemedicine during this crisis. |

## Place of Service

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| What place of service (POS) should I submit on my claims submission for services provided via telemedicine? | **For Medicare claims:**<br>When billing professional claims for non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency use the Place of Service (POS) code that would have been reported had the service been furnished in person along with a modifier 95, indicating that the service rendered was actually performed via telehealth. For example, a physician practicing in an office setting who sees patients via telehealth would report POS 11 (Office).<br>In ordinary circumstances providers use POS 02 (Telehealth) code to indicate the billed service was furnished as a professional telehealth service from a distant site. During the Public Health Emergency, CMS recognizes that physician practices are transitioning a potentially significant portion of their services from in-person to telehealth visits during the COVID-19 pandemic, yet still incurring resource costs just as they would if services were still furnished in person.<br>CMS states that practices may continue to use POS 02 "should [they] choose, for whatever reason," but will be paid using the lower facility payment rate.<br>**For commercial payer claims:**<br>We encourage members to review their payers' website for coding related guidance specific to telehealth services during COVID-19 as POS guidance may vary. |

## Time

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| Is time spent with a caregiver allowed to be considered as time with the patient? | If the patient is present and it is part of the actual visit, e.g., with a pediatric or dementia patient, yes it can be counted. If not, you may use the code for non-face-to-face encounter. |
| Does the time spent preparing for a telemedicine visit such as records review count towards total visit time? | You can use two codes, one for the telemedicine visit and prolonged service code 99358 for record review if the time threshold is met. This is for non-emergent telemedicine visits like stroke codes. |

## Modifiers

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| It is our understanding that for new and established patients we can bill for any of the E/M levels as long as the appropriate modifier is attached. Is this correct? | Not entirely correct. Certain face-to-face E/M services (found on Appendix P of the 2020 CPT codebook) can be delivered via telemedicine and reported with the use of a modifier if all of the necessary elements of the E/M encounter are met. Historically, initial hospital care codes, for example, could not be reported with a modifier, rather are reported with the appropriate G-code. On March 30, 2020, CMS loosened restrictions for inpatient coding. A full list of allowed codes is available here. |
| Can you please clarify when modifier 95 should be used vs. the GT modifier? | In general, you can append GT to any CPT code for services that were provided via telemedicine. It is most often used for codes like 99201–05 or 99211–15. Modifier 95 is similar to GT in use cases, but, unlike GT, there are limits to the codes that it can be appended to. Modifier 95 is only for codes that are listed in Appendix P of the CPT manual. Modifier requirements can vary among payers, so it is important to review your coverage policies prior to submission. |

## E-Visits

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| Is communication through the EHR billable as an E-Visit? | Yes, This would be reported with either G2010 or 99421, 99422, 99423. |

## Audio Only

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| Some of my patients do not have FaceTime on their phone or access to any other video technology. Is my only option a telephone visit? | If the visual/video component of the encounter is not present, you would report a telephone consultation code or the digital E/M codes (99421–99423) as they are asynchronous. |
| If a video encounter is interrupted or connection fails midway through the encounter and rest of the visit is conducted by phone, what is the documentation needed and how should I bill for this? | If you've completed the critical portion of the encounter while video is live you can still use an audio/video code. |
| When documenting the encounter, should the start and stop time be noted or is a comment of "11 minutes were spent discussing with patient" sufficient? | While there is not a universally accepted attestation statement, total time spent with patient should suffice; you do not need to document start and stop time of the encounter. |
| How are 99441–99443 (telephone E/M service) codes different from 99211–99215 codes? | 99441–99443 are specific to a telephone encounter with an established patient and are not a result of an E/M provided within the previous seven days, OR within the next 24 hours. 99211–99215 are reported for a full E/M encounter with the same documentation requirements as an in-person service. |
| Several my recent follow up patients requested no video for their follow up visits. Can I bill as a regular 99213 or 99214 by time with the appropriate modifier? | No, in order to report a CPT code for synchronous real time telemedicine services (indicated by modifier) the interactive telecommunications equipment must include, at a minimum, audio and video. In this situation you would need to report the appropriate level telephone consultation code. |
| Is G2012 specific for Medicare and 99441–99443 for Medicaid? | No. Commercial payers also cover G2012. In the past Medicaid was the only payer that covered the telephone CPT codes 99441–99443. However, as of March 30, 2020, CMS will cover telephone E/M codes 99441–99443 for the duration of the emergency declaration. |
| Can you clarify the difference between G2010 and G2012? | G2010 is reported for the physician review of a recorded video or image submitted by the patient and follow up with that patient (i.e., store and forward.)<br>G2012 is reported for brief communication/virtual check lasting five to 10 minutes between physician and patient. |

## Visual and Audio

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| The slide listing face-to-face codes that can be delivered via telemedicine included 99231–99233 (subsequent hospital care codes.) Are 99222–99223 (initial hospital care codes) also covered? | In the past, no, the 2020 CPT Code book provides a list of services that can be reported for the delivery of synchronous telemedicine (with Modifier 95) and does not include initial hospital care codes. CMS created G-codes G0406, G0407, and G0408 (follow-up inpatient consultation) can be reported for Medicare patients. HOWEVER, as of March 30,2020, CMS will cover initial hospital care codes delivered via telemedicine for the duration of the emergency declaration. |
| Can you elaborate on billing the different levels when exam is limited and basing it on medical decision making/complexity? It seems like you cannot really bill based on time due to lack of "counseling and coordination of care." | You can bill by time. If you spend over 50 percent of the visit speaking with the patient about their illness, diagnostic, and therapeutic plans that will count, just like in person visits. |
| If you perform a telehealth E/M and decide that the patient must come into the office, can you bill for both the telehealth visit and the office visit if performed on different days? | No, the telephone E/M consultation codes (99441–99443) cannot be reported if the call leads to an E/M service or procedure within the next 24 hours or soonest available appointment. |
| When are hospital follow-up CPT codes (99231–99233) used versus G-codes for inpatient follow ups? | Code selection varies depending on if the patient is a Medicare beneficiary or not and if the service is synchronous. 99231–99233 are recognized as services that can be reported (with modifier) for subsequent hospital care. CMS created G-codes G0406, G0407, and G0408 (follow-up inpatient consultation) can be reported for Medicare patients. |
| Are the G0425–G0427 inpatient initial consult codes appropriate if there is NO video component? (I.e., patient/ family contacted by phone while in the hospital to discuss symptoms, etc., and video is not available.) | No, in this situation you would need to report the appropriate level telephone consultation code. |
| What is the appropriate code if the patient is in the Emergency Room? | G0425, G0426, or G0427 can be reported for a telehealth consultation, emergency department or initial inpatient. On March 30, 2020, CMS loosened restrictions for inpatient coding. A full list of allowed codes is available here. Code selection is based on time spent communicating with the patient. |
| Frequently, we call patients to discuss lab results. Could we use G2010, and if not, what code should we report when using audio-visual to review lab results with a patient? | No, as G2010 is reported for the physician review of a video or image forwarded from the patient. Review of lab results cannot be separately billed. If the results are incorporated into a separate E/M service, bill as such. |

## PAYER / COVERAGE QUESTIONS

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| Where can I find a list of commercial payers' guidelines regarding telemedicine? | American Health Insurance Plans (AHIP) has a list of compiled commercial payers accessible here for COVID-19 response to telemedicine. It is always recommended to check with a payer to ensure a patient has telemedicine coverage under their benefits. |
| Is there a specific modifier for Medicaid? Or does it depend on the state? | Every state varies on how they accept modifiers. We recommend you check with your state Medicaid to see if or what modifiers should be used for telemedicine coverage. |